

INDIVIDUALIZED REVIEW Claim Form

CELOTEX ASBESTOS SETTLEMENT TRUST

Submit completed claims to:
Celotex Asbestos Settlement Trust
P.O. Box 1036
Wilmington, DE 19899-1036

Instructions for the Individualized Review Claim Form

Complete this claim form as thoroughly and accurately as possible. Please type or print neatly.

Should there be insufficient space to list all relevant information, please attach additional sheets.

In addition to filing the forms that follow, please ensure the following are enclosed, if applicable:

- Death Certificate (if applicable)
- Certificate of Official Capacity (if personal representative is filing form)
- Medical Records as requested in instructions
- Proof of Celotex or Carey Canada product exposure as set out in instructions

Representation

If Claimant is represented by counsel, please print or type the following information:

Attorney Name: _____
(Please print full name)

Paralegal or Contact Name: _____
(Please print full name)

Name of Law Firm: _____
(Please print full name of firm)

Firm Address: _____
(Street/PO box number/suite number)

(City, State and Zip)

Attorney Phone: _____
(Area Code & Number)

Fax: _____
(Area Code & Number)

Contact Phone: _____
(Area Code & Number)

Fax: _____
(Area Code & Number)

If the claimant is represented by counsel, please be sure that all information on this page is printed and legible

Part 1: Injured Party Information

Name: _____ Please enter the full name of the injured party

Gender: Male _____ Female _____ Please select the injured party's gender

Social Security #: _____ Please enter the injured party's Social Security Number

Date of Birth: _____ Please enter the injured party's complete date of birth
(Month) (Day) (Year)

I. Is injured party living? Yes _____ No _____

Select if the injured party is living or deceased

II. If injured party is living and not represented by counsel, please complete the following:

Mailing Address: _____
(Street/PO box)

(City/State/Zip)

If the injured party is living and not represented by an attorney, the mailing address and daytime phone fields need to be completed

Daytime Phone: () _____ - _____

III. If injured party is deceased: (**Death Certificate must be enclosed**)

Date of Death: ____/____/____

Is the injured party deceased? If yes, a Death Certificate must be enclosed and the question of whether the death is asbestos related must be answered

Was death asbestos related? Yes _____ No _____

IV. If injured party has a personal representative, indicate the following information (**enclosed.**)

If the injured party is represented by someone other than an attorney the following information must be completed

_____, his/her attorney, please **of Official Capacity must be**

Name: _____ Social Security Number: _____ - _____ - _____

Mailing Address: _____

Daytime Phone: () _____ - _____

Relationship to Injured Party: I am party's: _____
(Guardian, Administrator, Brother, etc.)

Part 2: Diagnosed Asbestos-Related Injuries

Place an X next to all injuries below that have been or were diagnosed for the injured party **and** for which medical documentation is attached to this claim form. *See Instructions for listing of medical records that must be enclosed.*

<input type="checkbox"/>	Other _____ (Specify)	Date of Diagnosis _____ (Month)
<input type="checkbox"/>	Bilateral Pleural Disease	Date of Diagnosis _____ (Month)
<input type="checkbox"/>	Non-disabling Bilateral Interstitial Lung Disease	Date of Diagnosis _____ (Month)
<input type="checkbox"/>	Disabling Bilateral Interstitial Lung Disease	Date of Diagnosis _____ / _____ / _____ (Month) (Day) (Year)
Other Cancer:		
<input type="checkbox"/>	Colo-rectal	Date of Diagnosis _____ / _____ / _____ (Month) (Day) (Year)
<input type="checkbox"/>	Laryngeal	Date of Diagnosis _____ / _____ / _____ (Month) (Day) (Year)
<input type="checkbox"/>	Esophageal	Date of Diagnosis _____ / _____ / _____ (Month) (Day) (Year)
<input type="checkbox"/>	Pharyngeal	Date of Diagnosis _____ / _____ / _____ (Month) (Day) (Year)
<input type="checkbox"/>	Lung Cancer (One)	Date of Diagnosis _____ / _____ / _____ (Month) (Day) (Year)
<input type="checkbox"/>	Lung Cancer (Two)	Date of Diagnosis _____ / _____ / _____ (Month) (Day) (Year)
<input type="checkbox"/>	Malignant Mesothelioma	Date of Diagnosis _____ / _____ / _____ (Month) (Day) (Year)

Select the appropriate disease(s) the injured party has been diagnosed with and the date the disease(s) were diagnosed. Please be sure to attach the medical documentation supporting each disease diagnosis.

Claims for all of the above injuries must include a diagnosis of the claimed disease by an internal medicine or pulmonary specialist or other specialist based on either a physical examination of the claimant by that doctor, a physical examination by another doctor whose physical examination and findings are reliable or a pathologist examination for a deceased claimant.

If reimbursement of medical expenses is being claimed, what was the total expenditure on diagnosis and treatment of asbestos-related diseases: \$ _____.

Part 3: Dependents and Beneficiaries

List any other persons who may have rights associated with this claim.

Be sure to include the injured party's spouse, any dependents who derive (or who did derive at the time of the injured person's death) at least one-half of their financial support from the injured party.

Also list beneficiaries who are entitled to pursue an action for wrongful death under applicable state law.

If more than four, please photocopy this page, and insert after current page.

Please list the person(s) who is currently (or who was at the time of the injured party's death) financially dependant upon the injured party. Be sure to also list any beneficiaries who may be entitled to pursue an action for wrongful death.

Name: _____	Date of Birth: _____
Relationship: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other: _____	Financially Dependent? Yes <input type="checkbox"/> No <input type="checkbox"/>

Name: _____	Date of Birth: _____ / _____ / _____ (Month) (Day) (Year)
Relationship: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other: _____	Financially Dependent? Yes <input type="checkbox"/> No <input type="checkbox"/>

Name: _____	Date of Birth: _____ / _____ / _____ (Month) (Day) (Year)
Relationship: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other: _____	Financially Dependent? Yes <input type="checkbox"/> No <input type="checkbox"/>

Name: _____	Date of Birth: _____ / _____ / _____ (Month) (Day) (Year)
Relationship: <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other: _____	Financially Dependent? Yes <input type="checkbox"/> No <input type="checkbox"/>

Part 4: Occupational Exposure to Celotex or Carey Canada Products or Operations

Proof of Celotex or Carey Canada product exposure must be enclosed. (See Instructions)

Please photocopy this page and attach to your claim.

Please enter complete beginning and ending date in which the injured party was exposed to Celotex or Carey Canada products

Do not allege exposure to asbestos.

Date Exposure Began: ____/____/____ (Month) (Day) (Year) Date Exposure Ended: ____/____/____ (Month) (Day) (Year)

Was the injured party employed by Celotex, Philip Carey or a Philip Carey Contract Unit during this time? Yes ____ No ____

Please be sure to complete the following questions regarding exposure to Celotex and Carey Canada products

Did the injured party work at a site while Philip Carey, Carey Canada or Celotex employees were otherwise handling asbestos-containing products during this time? Yes ____ No ____

Did the injured party work with Celotex, Philip Carey or Carey Canada employees during this time? Yes ____ No ____

Did the injured party live or work near or in the vicinity of a Carey Canada mine, or a Celotex or Philip Carey manufacturing plant or job-site where asbestos was present during this time? Yes ____ No ____

Occupation: _____

Please include the occupation in which the injured party was exposed to Celotex or Carey Canada products as well as a description of the duties while in this occupation

Description of Job Duties: _____

Industry in which exposure occurred: _____ (Code) If Code 37 (Other), specify: _____

Industry Codes

- | | |
|---|-------------------------------------|
| 10. Asbestos mining | 24. Petrochemical |
| 11. Aerospace/aviation | 25. Insulation |
| 12. Asbestos abatement | 27. Railroad |
| 13. Automobile/mechanical friction | 30. Shipyard-construction/repair |
| 16. Chemical | 31. Textile |
| 17. Construction trades | 32. Tire/rubber |
| 18. Iron/steel | 33. Utilities |
| 19. Longshore | 34. Asbestos products manufacturing |
| 20. Maritime | 36. Building occupant/bystander |
| 21. Military | 37. Other |
| 23. Non-asbestos products manufacturing | |

Please select from the list below the appropriate industry in which the exposure occurred

Describe how and why asbestos products were used at the site: _____

Please describe how and why asbestos products were used at the location or site

Employer: _____

Please enter the Site or Location where the exposure occurred including city and state

Site or Location of exposure: _____ Plant or Site Name: _____

Location at plant or site where exposure occurred: _____

Please describe in detail how the **injured party** was exposed to Celotex or Carey Canada products

City: _____ State: _____

Describe how injured party was exposed to Celotex or Carey Canada product(s) or operations: _____

Please enter **specific** Celotex or Carey Canada Products names to which the injured party has been exposed

Name of Celotex or Carey Canada product(s) or operations to which injured party was exposed: _____

Part 5: Exposure to an Occupationally Exposed Person*

Is the claimant alleging an asbestos-related disease resulting solely from exposure to an occupationally exposed person, such as a family member (spouse, father, sister, etc.)?

Yes _____ No _____

Date Exposure to Other Person Began: Month _____ Year _____

Date Exposure to Other Person Ended: Month _____ Year _____

Relationship to occupationally exposed individual:

I am his/her _____
(Brother, Son, Spouse, etc.)

Describe how injured party was exposed to the Celotex or Carey Canada product:

Four horizontal lines for describing exposure.

Please be sure to complete the following **only if** the claimant is alleging an asbestos-related disease resulting solely from exposure to an occupationally exposed person

Please describe in detail how the injured party was exposed to Celotex or Carey Canada products

*Part 4, page 5a, must be completed for the occupationally exposed person.

Part 6: Smoking/Tobacco History

For each item, indicate whether injured party has smoked or used the given product. If used, indicate the dates they were used, and the amount per day. Indicate fractional packs as appropriate, e.g. three and one-half packs would be entered as 3.5.

Has the injured party ever:

Smoked Cigarettes? Yes _____ No _____

From / To: / Packs per day: _____.

(Month) (Year) (Month) (Year)

From / To: / Packs per day: _____.

(Month) (Year) (Month) (Year)

From / To: / Packs per day: _____.

(Month) (Year) (Month) (Year)

From / To: / Packs per day: _____.

(Month) (Year) (Month) (Year)

Please indicate whether the injured party smoked or used tobacco. If yes, please enter the dates the product was used and the amount per day.

Has the injured party ever:

Smoked Cigars? Yes _____ No _____

From / To: / Cigars per day: _____.

(Month) (Year) (Month) (Year)

From / To: / Cigars per day: _____.

(Month) (Year) (Month) (Year)

From / To: / Cigars per day: _____.

(Month) (Year) (Month) (Year)

From / To: / Cigars per day: _____.

(Month) (Year) (Month) (Year)

Part 7: Asbestos Litigation

Has a lawsuit ever been filed on behalf of the injured party?

Yes _____ No _____

Please answer whether a lawsuit has been filed on behalf of the injured party. If yes, please answer the remaining questions

Two-letter abbreviation of the state in which the suit was originally filed: [] []

Name of court in which suit was originally filed: _____

Please complete the following information regarding the venue in which the lawsuit was filed

Date on which the suit was originally filed: _____ (Month/Year)

Has injured party received settlement money from Celotex or Carey Canada? Yes _____ No _____

Please provide the Aggregate Settlement Amount received from all asbestos defendants:

\$ _____

What is the current status of this suit?

- Pending
Dismissed
Judgment
Settled

Please select if a trial date has been set, if yes enter the appropriate date

If this suit is pending, has a trial date been set? Yes _____ No _____

If yes, when is the trial currently scheduled? (Month) / (Day) / (Year)

If no, what is the earliest date trial could be expected? (Month) / (Day)

Unless you wish to waive your right to have your claim allowed, evaluated and paid by the Trust, you must notify the Trust when a trial date is established.

If this suit has been dismissed or has received a judgment, please provide the following information:

Date of Verdict Name of Defendant(s) Verdict Amount

(Month / Year) \$ _____

Blank lines for providing defendant names and verdict amounts.

Part 8: Workers' Compensation/Other Disability Claims

Has the injured party ever received disability benefits related to asbestos?

Yes _____ No _____

Name of organization granting benefits: _____
(FECA, WC, etc.)

Complete this page **only if** the injured party has received workers' compensation or any other disability benefit

Date benefits began: _____ / _____
(month) (year)

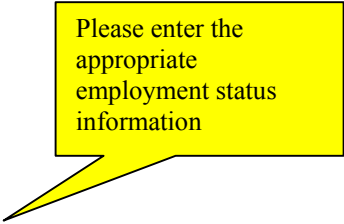
Monthly benefit stipend: \$ _____, _____.

Name of company claim was filed against: _____

Part 9: Employment Information

Current Employment Status:

- Full-time, outside the home
- Full-time, within the home
- Part-time, outside the home
- Part-time, within the home
- Retired
- Disabled



Amount of last annual wage: \$ _____,_____._____

Date of last wage received: _____/_____
(month) (year)

(enter current month and year if currently earning work-related compensation)

W-2 and first page of Form 1040 for last year of full employment must be enclosed, if lost wages are being claimed.

PART 10: SIGNATURE PAGE

All claims must be signed by the claimant, or the person filing on his/her behalf (such as the personal representative or attorney).

I have reviewed the information submitted on this claim form and all documents submitted in support of this claim. To the best of my knowledge under penalty of perjury, the information submitted is accurate and complete.



Please be sure that the claim is signed by the claimant or the person filing on his/her behalf

Signature of Claimant or Representative



Please be sure that the name of the signatory above and relationship are printed and legible

Please print the name and relationship to the claimant of the signatory above.

Please review your submission to ensure it is complete.

- Death Certificate (if applicable)
- Certificate of Official Capacity (if personal representative is filing form)
- Medical Records as requested in instructions
- Proof of Celotex or Carey Canada product exposure as set out in instructions

Please check the appropriate boxes to ensure completion of the claim form